that there is a real difference here between these two bills.

As the gentlewoman said, my colleague from Texas, they are giving lip service to the Patients' Bill of Rights, but they are not really for the real Patients' Bill of Rights.

I yield back to the gentleman from Texas (Mr. RODRIGUEZ.)

Mr. RODRIGUEZ. Mr. Speaker, I would hope that when people provide lip service, I would hope that we judge people on what they also do. So when they give it lip service, I am hoping they will go beyond that and start acting in an appropriate manner.

But when we talked about rural health care, they came up with tort reform. If they use it for political reasons to get after and reward their friends and do in their enemies, then that really upsets me and angers me. I saw the tones of that when they got up here.

The majority of people do not like attorneys. I am not one, and I do not know if the gentleman is one. I apologize if the gentleman is. But the bottom line is that we have the judiciary for a reason. Those judges, I respect the judges out there, with the exception of the Supreme Court in the last decision that they made. Beyond that, most judges do the right thing. We would expect that people would go only to the judiciary in the last resort.

With our piece of legislation, it allows a review board, and it allows that review board to be able to look at that data before any court decision. So it would be very obvious to anyone if something wrongful had occurred. And if it does occur, and if it occurs with one's loved one or anyone, then that person deserves to receive justice if they were denied access to a certain care that caused them injury.

So I think that is important, and that ultimate right still belongs to every American. It should not be taken away by the insurance companies of this country. Just because they have paid insurance all their lives, and all of a sudden they are sick and find themselves not having access to the quality care they had been paying for and had been promised, and they find themselves once again fighting the disease and the illness and also fighting the HMOs, then they would wonder, where are our politicians? Where are they?

We have been trying to make this happen, and I hope that they are sincere about trying to make something happen and make people accountable, and make those insurance companies accountable for doing the right thing when those people find themselves in need.

Mr. PALLONE. I appreciate the gentleman's comments. I yield to the gentlewoman from Texas (Ms. JACKSON-LEE), Mr. Speaker.

Ms. JACKSON-LEE of Texas. Mr. Speaker, the gentleman made a slight comment as he was describing the Fletcher bill procedure, and he said he was sounding like a bureaucrat. No, the gentleman was explaining the bureaucracy that the Fletcher bill was now going to recreate to inhibit the direct review or direct opportunity to hold HMOs accountable.

Fingers do not last long that are detached, and emergency surgery or needs for immediate care cannot tolerate scientific review and paperwork review and computer review and standards review. They can tolerate a trained specialist or physician looking at the facts with the patient before them, consulting with their colleagues and making an immediate decision to save this person's life.

What I see is a pitiful response to the outcry of Americans about care and the relationship between physicians and patients. It is creating this whole new established bureaucracy that does nothing but delay the decision. If I have to get my child into an emergency room circumstance with a pediatric specialist at hand and if that is denied me, then I may shorten the opportunity for my child to recuperate.

We have seen some tragic incidences occurring with children just this summer. When the summertime comes, we know that children engage in fun, but we also know it opens them up to various incidents that occur. They need immediate health care.

I would say to the gentleman, no, he is not the bureaucrat, but the Fletcher bill would certainly create a whole new independent set of bureaucracies that do not get care to the patient. I just think that we should come together in this House and the Senate and vote for the real Patients' Bill of Rights.

Mr. PALLONE. I want to thank the gentlewoman, and both of my colleagues from Texas.

I think we only have another minute or so. I wanted to say that my real concern, of course, is that we never get a chance to vote on the Patients' Bill of Rights this week or even this year. We know that the leadership, the Republican leadership, has promised that the bill will come up for a vote this week.

We are going to hold them to the fire on that, that it must come up and that we must have a clear vote, a clean vote on the real Patients' Bill of Rights. We will be here every night, if necessary, this week to make that point until that opportunity occurs.

BORDER HEALTH

The SPEAKER pro tempore. Under the Speaker's announced policy of January 3, 2001, the gentleman from Texas (Mr. RODRIGUEZ) is recognized for 60 minutes.

Mr. RODRIGUEZ. Mr. Speaker, I was just here talking about the Patients' Bill of Rights and how important that issue is. I want to take this opportunity tonight to begin to talk a little bit about border health.

Mr. Speaker, I rise today to call attention to the poor state of health along the U.S.-Mexican border. The United States-Mexico border reaches approximately 2,000 miles, from the Pacific Ocean in the West to the Gulf of Mexico in the East.

More than half of this border, over 1,248 miles, is shared with Texas. It is a vast region, and each of the four southwestern border States have a unique history and community dynamics.

However, Texas, California, Arizona, and New Mexico's borders all share the plague of persistent socioeconomic problems largely ignored by the rest of the Nation.

□ 2130

If the United States border region of Texas were declared the 51st State, and we say this and we kind of talk in Texas about the fact that we are one of the few States that has a law that says we can divide our State into five States if we wanted to, but if we were to make the 51st State on the border of Texas, taking those counties into consideration, it would rank as one of the poorest in terms of access to health care, second in the death rate from hepatitis, and third in the death rate of diabetes. The rate of the uninsured is among the highest in the country, as are the poverty rates.

In Texas and New Mexico, an estimated 30 percent of the border residents have no health insurance, and in Arizona it is estimated at 28 percent, and the estimates in California are 19 percent. So that what we have throughout the border area is a very large lack of access to health care.

I am relieved that there is finally a focus on health care and this has dominated both of the campaigns in the previous elections. There is some talk about the importance of border health now, although this focus had not been there before. Since the focus has started now and some dialogue has started, we are hoping to be able to get revenues to the border.

I strongly support all the efforts that have been made to pass a comprehensive Patients' Bill of Rights, and we are going to continue to move forward on that, but I urge my colleagues to also look at the issues of access and especially in underserved communities such as the border.

Oftentimes, the emergency rooms end up being the first line of care for residents in underserved areas like the border. It is also true that health disparities along the border are enormous. For those of my colleagues who have ever visited the border, any of the areas I represent, Starr and Zapata on the border are the two counties I have of which are in my district, both Starr County and Hidalgo County, not in my district, these two counties included are among the four poorest counties in the Nation. So we have a great deal of

poverty associated with lack of access to health care.

The district that I represent faces many health and environmental challenges. The poor state of infrastructure leads to real health and environmental problems, including hepatitis, diabetes and tuberculosis. Health problems are compounded by low per-capita income, lack of insurance, and lack of access to health care facilities.

There is no question that the border region is crying out for increased resources in the face of so many challenges. Tuberculosis has emerged as a serious threat to public health along the border. One-third of the new TB cases in the U.S. were from four southwest border States. Once again, one-third of all the cases in the United States come from the border.

The ease with which an individual can contract the tuberculosis bacteria is often frightening. Often someone needs to do no more than breathe in the tuberculosis bacteria coughed into the air by the infected individual. Currently, 15 million Americans are infected with tuberculosis, which means we are all at risk. So this disease hits some communities more than others.

Regions which have high levels of tourism, international business and immigration experience higher than average levels. For instance, Texas has one of the highest tuberculosis rates in the country now. My State ranks seventh nationwide in the incidence of tuberculosis, with TB rates of 8.2 percent per 100,000. Even more sad is that minorities suffer disproportionately. Latinos in the United States have a tuberculosis rate six times that of Anglos.

Tuberculosis is not the only disease of which the border residents are hit disproportionately. They also suffer from diabetes.

When we look at diabetes, the border has a higher mortality rate than the rest of the country. Again, I will use the Texas statistics. In 1995, the Texas diabetes mortality rate was nearly 50 percent higher than the rest of the United States. Gestational diabetes and Type II diabetes hit the Spanish population in greater numbers than other populations, and it is the Hispanic population that makes up the larger percentage of border residents. It is unacceptable that such a high number of border diabetes patients die from disease that can be controlled and even prevented.

When we consider the effect that environmental pollution has on health, it gets even worse. Last week we debated whether to let Mexican trucks into the United States. I cannot stress again how important it is that these trucks meet U.S. safety standards, especially when it comes to emissions. Our air quality along the border is threatened due to the increased truck traffic brought about through NAFTA. More children than ever are developing respiratory problems, such as asthma, causing them to miss school, extracurricular activities and, even worse, to be hospitalized.

Water pollution poses a serious health hazard, including the spread of Hepatitis A and parasitic infections. Hepatitis A, spread mainly through unclean food and water, is two or three times more prevalent along the Mexican border than the U.S. as a whole. The presence of lead in water can cause damage to developing brains, the nervous system of children, and affects reproductive systems in adults.

Residents in colonias are even more at risk from environmental health-related problems. Colonias are rural unincorporated communities characterized by the lack of certain basic public services, such as drinking water, sewage disposal, garbage pickup and paved roads. For instance, 86 percent of the individuals living in Texas colonias in the year 2000 had water but only 12 percent had sewage disposal.

As my colleagues can see, what I am describing is not on the Mexican side, I am talking about the U.S. side, and we are talking about the boarders between Texas, New Mexico, Arizona and California. Mr. Speaker,the border regions between the U.S. and Mexico are an area of great potential and challenge, especially with respect to the health and environmental concerns that our two nations face.

What is the cause of the border health disparities? The lack of health education, low reimbursement rates to our health care providers, the lack of access to health care facilities, and the chronic shortage of health care professionals. In addition, the poor data collection has left us in a situation where we do not have all the information needed to solve the problems that confront us. Disparities in the reimbursement rates for Medicaid and the SCHIPs, along with the consistent lack of health care professionals are some of the problems that have been confronted.

I want to take this opportunity to also mention that we have had the opportunity to go through the border. We recently had a town hall meeting in El Paso with my colleague, the gentleman from Texas (Mr. REYES), and one of the things, as we get the data that deals with the disproportionate disparities that exist on the border regarding health, is that despite the fact that we get resources from the Federal Government, such as Medicaid, for example, that we still find some disparities within the States.

One of the great ironies was some testimony that was provided by a county judge from El Paso, Dolores Briones, and I want to read part of her testimony that she gave us. She talked about the ironies that have recently been discovered in our State, and I am going to read from her testimony.

Our State, referring to Texas, Medicaid budget actually benefitted from the high poverty rates along the border when drawing down Federal dollars. That is, because of the poor people in south Texas, the State of Texas is able to leverage additional resources that they would not necessarily be able to.

Right now, those funding formulas for the Texas Medicaid program allows the State to draw down $1.50 of every State general revenue dollar spent on Medicaid services. That is what we call the 60–40 split. That is that for every 40 cents we put in, we get 60 cents. This split of funding responsibility is recalculated each year for each of the States, and it is based upon the State's per capita income.

I mention this because it is real important that my colleagues stay with me and follow through. We get those monies based on per capita income when compared to the national average per income levels. The lower the State per capita income, the higher the Federal share. That means that Texas gets additional resources because of the poor people that live on the border.

The testimony we received is that the State of Texas actually benefits from the high poverty based on per capita income and child poverty, El Paso and other border counties. Without the borders, the State of Texas would only be getting a statistic of 50 to 50 instead of 40 to 60 percent, which is a minimum of Federal matching rate allowed under Medicaid.

A separate calculation for the area, if we just took the lower region and if we took that calculation, the lower counties should get 83 cents for every 17 cents we put in. The bottom line is, when the money comes down and the formulas are distributed and the State gets that money, they reimburse Houston and some of the communities and Dallas in the north at a higher rate than they do San Antonio, than they do the rural area, than they do El Paso. So here they are leveraging that money based on per capita, based on the low-income population and, at the same time, as they receive those resources, they choose to distribute them on a formula that discriminates against those same poor that were able to leverage those resources for them.

It was very startling information that was provided by the county judge. She talked about the fact that she was going to do everything she could to come to grips with that issue, to make sure that those monies followed those patients and that it go to those areas where those patients are in need. And the areas that are a little more affluent such as Dallas and Houston should not be leveraged at higher rates if they do not have the same formulas or the same per capita. The region and the border should be getting a higher rate, San Antonio included.

So when we look at that disparity, we see some of the problems that exist

and that we need to begin to clarify. And she indicated that she was looking at it and, if she had to, was going to go into litigation over the issue. My colleague, the gentleman from Texas (Mr. REYES), and other Members of Congress from Texas asked the GAO to do an assessment of each of the States as to how this money was being handled. So it is something that needs to be looked at.

It is something that is serious. It is something that we need to come to grips with in making sure that if those monies are going down there to help those people that are in need and if it is followed based on a formula that talks about how important it is because of the fact that they are poor and it is per capita, then one would think they would be receiving the money, yet they get disproportionate monies. What it does is it creates a real difficulty because of the reimbursement rate for our doctors on the border, which is much less, for our hospitals it is much less than it would be in Dallas or Houston or elsewhere.

So that is unfortunate. But, hopefully, we will continue to work on that specific issue as we move forward.

I also want to take this opportunity to just give a few statistics about the border. It is important to note that, in 1995, approximately 10 million people lived along the border, with 55 percent in the United States and 45 percent in Mexico. A lot of times we do not take into consideration that these communities have sister cities right across and there are major populations. So it is important for us to remember that.

When we look at the problems of tuberculosis, it is not just the population that we have in El Paso or the population that we have in Laredo. We have to consider the populations on the other side also that have a direct impact. So it becomes real important that we keep that in mind. So for health care, which is the issue that I am talking about, it is one of the areas that we also need to be very conscientious of.

We talked about tuberculosis. As my colleagues may well know, tuberculosis can be spread by just talking in front of someone, as we breathe the air. It is very serious. Tuberculosis, a very infectious disease, up to six or seven prescriptions are needed. It has to be fought for over 6 months, and if it is not fought and the medication not taken during that period of time, we find a situation where those particular prescriptions will no longer work on that particular illness.

□ 2145

We find out now that in tuberculosis, we are finding that there are some strands that we are having difficulty with because we do not have medications to treat them.

Mexico treats tuberculosis with less prescriptions, and a lot has to do with cost. We really need to battle tuberculosis on the border. We need to battle it wherever it is throughout the world because when it comes to infectious diseases, it is like preventing a war. If you can prevent something, it is better than having to send our troops to deal with it. The same thing with access to infectious diseases. We need to treat them because later on we will find other forms of the disease that you are unable to treat because people did not take the medication appropriately the way that they should.

When we look at AIDS, the disparity in AIDS also exists. There is a tremendous amount of AIDS. We see the statistics of Hispanics based on their population figures. It is beginning to hit those populations that are poor. We know in the area of AIDS there is some new information that you can begin to test yourself, and you can identify whether you have AIDS or not much earlier, which has a direct impact on being able to take care of yourself and taking care of those persons that are inflicted with that disease.

It is important that we do that as quickly as possible. Once again, one of the problems that exists is with the poor. It is one thing to know that they have diabetes or AIDS, but it does not do any good unless patients have access to good care. It becomes more important with infectious diseases such as tuberculosis and AIDS that we provide that access. One might say why should I care about that, it is not in my area. We should all care because eventually if we do not take care of it, we are going to find some strands that we will not be able to defeat, such as the strands in tuberculosis that we need to come down on.

Mr. Speaker, as we talk about the border States of Arizona, New Mexico, and Texas, we find the same problems in terms of the demographics, in terms of the lack of access to good quality care, the problems of not having access to insurance, and we do have Medicaid for our indigent, but one of the things that we find is if you are not indigent and you are working on the border, and a lot of times small companies do not have access to insurance. If you do not have access to insurance and you are trying to make ends meet, you find yourself in a situation if you get sick or your child gets sick, you find yourself in trouble. Thank God we were able to establish the CHIPs program which has helped a lot of youngsters of parents who are working and trying to make ends meet to get covered with insurance, but we need some additional efforts in that area. We do need to do the outreach. We need educational programs. We have done some good studies on diabetes. In fact, some initial studies on diabetes were on the border, Starr County, where we have been able to detect it earlier in life. The only way it is good information is if we do something about it. As we have found a way of being able to identify whether a person has diabetes or not, now we have to provide access to care and the possibility of being able to get rid of those problems that they encounter.

I want to take this opportunity to mention the current border population is a little over 11 million. In the first 5 years up to July 2000, the border area population has continued to increase by 25 percent.

If you look at the year 1986, 806 maquilladoras existed in the six border States. But a decade later, we have over 1,500 maquilladoras. 1997 estimates show that over 2,000 plants employed more than 600,000 Mexican workers on the borders. We have a good deal of growth on both sides.

One of the larger metropolitan areas is the city of Laredo, and it continues to grow on the U.S. side. On the Mexican side we have similar growth throughout the border region. Although poverty is a common element shared with both United States and Mexico, the U.S. side of the border is more impoverished than the rest of the United States, with over 33 percent of the families living at or below poverty levels. In Texas the statistics are 35 percent of all of the families, and 40 to 50 percent of the families in some of the border counties are living at or below that poverty level.

Three of the U.S. border counties are among the 10 poorest counties in the United States. As I indicated, Starr County, that I represent, is one of the poorest. Tonight what I want to share is that there is a need for us to look at the border. We need to look at it from the perspective of also being part of this United States. We have to look at the colonias that are out there.

There has been a great deal of efforts on the part of the States to stop that type of growth, and we do need to stop that growth from that perspective because it is growth that is not planned growth, is without good quality water, and we need to make every effort to make sure that those people, those individuals that still reside on the border, have access to good housing. It becomes important that we provide them with that access without the stumbling blocks of having those colonias that exist on the border.

Mr. Speaker, I want to take this opportunity to give a little data on California's border. One the issues talks about the problem of diabetes all along the border, and the fact that people have gone blind. The sad thing is that it could have been prevented. Now we have gotten to the disease so we can prevent a great deal of blindness that occurs through diabetes. And amputation, people have lost their limbs as a result of diabetes. In a lot of those cases, it is preventable. Some it is not, but in most cases it is preventable. It could be worked on, and these are important things for us to remember.

On the HIV-AIDS situation, as we all know, we can look at the data and say it is looking great. We have made some inroads, but the bottom line is the numbers are increasing for the socioeconomic areas of our country. Those increases are going to be more harshly hit because these are the people who do not have access to good quality care. These are people who do not have access to the resources needed to respond to issues such as AIDS. If you are wealthy and have insurance, you can almost survive AIDS. But if you do not, you are going to find yourself not being able to sustain life and also not even knowing about it until it is almost too late.

As we look at the border, we look at our children's health and the importance of vaccinations in providing access to good quality health care, there have been some efforts with community mental health centers in assuring that we provide that care. I do want to take this opportunity to thank those centers for their efforts throughout the country, and especially on the border in providing access to health care. They have people working out there, people working in communities providing that access to that care, and making sure that those people have access. We still need a lot more resources.

In addition to that, we have talked about the environment. We talked about water pollution. Remember that on both sides we still need sewage plants, not only on the United States side but the Mexican side also. We drink water from the Rio Grande. We find ourselves in a real bind in terms of the quality of that water. So every effort needs to be made to make sure we have good quality drinking water.

When we look at air pollution, it is no coincidence that El Paso has not been able to meet EPA standards. No matter what El Paso does, they are going to have difficulty meeting those standards mainly because of colonias. So colonias needs to be considered when looking at the formulas. You cannot consider one side of the river without looking at the other side, and making sure that good quality care exists on both sides because we breathe the same air and drink the same water and we are affected as we communicate with each other.

Mr. Speaker, the border has a lot of positives. It has a lot of enthusiasm. It has a lot of people moving forward. There are a lot of things happening that are great, but part of that is making sure that we have good quality care. I want to take this opportunity and maybe I will do it at a later date, to talk about the information regarding some of the other States. I know in New Mexico there are 167 miles along the Mexican border area comprised of five counties in that region. You will find some disparities that exist in the area of health care, and those disparities are evident not only in New Mexico but throughout. I want to mention a couple of other things.

I know one of the main disparities that exist in New Mexico when you look at tuberculosis cases, they find that you have a large number of tuberculosis cases also all along the border, and New Mexico is no exception. As well as Arizona. Arizona finds itself in the same situation, as well as California. So the whole border region is an area that we need to continue to focus on.

Mr. Speaker, I am very pleased if nothing else with the issue of NAFTA. For those who opposed NAFTA, you have to admit that at least NAFTA has allowed us an opportunity to focus. In Texas, very seldom did we talk about the border. The State of Texas never focused on it. It continued to neglect it, and because of the importance of trade, because they saw the value of our neighbor to the South, now there is a great deal of focus.

Along with that focus once again should come the real concern of meeting the needs of the community in that area, and those needs are translated in the form of resources for access to good quality care.

I am hoping as we move forward, we will continue to look at getting resources for access to health care; and I am hoping as that county judge from El Paso testified, that we can start looking at those disparities and making sure that those resources when they come to Texas, and those States on the border, that they come to those regions where they are needed the most and allow them to be able to leverage those resources in order for them to be able to fight the diseases I have mentioned.

□ 2200

I want to thank everyone who has been here tonight. I know that we had some opportunities to be able to dialogue about the importance of these issues. I want to just indicate that there has been some discussion on the issue of medication. I just want to briefly indicate that along the border, there is a study that was done where nearly 40 percent of a survey reported that someone in the immediate household, 40 percent, received their medications on the border from Mexico. We find a population that is seeking out for access to health care, they are not finding it on this side, they are seeking it elsewhere in Mexico, and there are some pitfalls to that. There are some positives also, but there are some pitfalls. Some of the pitfalls that I have indicated are like the problems that we find with tuberculosis that in Mexico is not treated in the same way that we treat it. We provide it with a lot more medication than they do. That could create some serious problems for all of us if it is not treated appropriately. Secondly, as they go across, one of the main prescriptions that they get deals with uses for colds and some uses, 30 percent, were for blood pressure, 50 percent were for heart disease, 20 percent for diabetes.

As we move forward, I am hoping that Congress at the national level, that there is a responsibility to meet and that when people live on the border and people come across the border that we as a Nation have a responsibility to also provide access to good quality care for not only all the people on the border but also those people that get impacted by people from the other side of the border.

LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to:

Mr. ABERCROMBIE (at the request of Mr. GEPHARDT) for today on account of official business.

Mr. BACA (at the request of Mr. GEPHARDT) for today on account of a death in the family.

Ms. CARSON of Indiana (at the request of Mr. GEPHARDT) for today on account of official business in the district.

Mr. CRANE of Illinois (at the request of Mr. ARMEY) for today on account of travel delays.

Ms. KILPATRICK (at the request of Mr. GEPHARDT) for today on account of official business in the district.

Ms. PELOSI (at the request of Mr. GEPHARDT) for today on account of a flight delay.

Mr. SCARBOROUGH (at the request of Mr. ARMEY) for today, July 24, and July 25 on account of attending a memorial services for a former staffer.

Mr. SHERMAN (at the request of Mr. GEPHARDT) for today on account of airline mechanical problems.

Mr. STARK (at the request of Mr. GEPHART) for today on account of medical reasons.

Ms. WATERS (at the request of Mr. GEPHART) for today on account of official business in the district.

SPECIAL ORDERS GRANTED

By unanimous consent, permission to address the House, following the legislative program and any special orders heretofore entered, was granted to:

(The following Members (at the request of Mr. DEFAZIO) to revise and extend their remarks and include extraneous material:)

Mr. DEFAZIO, for 5 minutes, today.

Mr. DAVIS of Illinois, for 5 minutes, today.

(The following Members (at the request of Mr. TIAHRT) to revise and extend their remarks and include extraneous material:)

Mr. OSBORNE, for 5 minutes, today.

Mr. WICKER, for 5 minutes, today.

Mr. TIAHRT, for 5 minutes, today.